FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0046052

Facility Name: Bement Health Care Center

Address: 601 North Morgan Street (Number) Bement (City) 61813 (Zip Code)

County: Piatt

Telephone Number: (217) 678-2191 **Fax #** (217) 678-7521

IDPA ID Number: 371346306001

Date of Initial License for Current Owners: 02/02/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover Telephone Number: (312) 384-6000
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	60	Skilled (SNF)	60	21,960	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,960	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,405	1,405	8
9	SNF/PED					9
10	ICF	12,012	7,090	82	19,184	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,012	7,090	1,487	20,589	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.76%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/02/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/02/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 8 and days of care provided 1,405

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	93,219	7,543		100,762		100,762	4,483	105,245			1
2	Food Purchase		88,266		88,266		88,266	(3,094)	85,172			2
3	Housekeeping	50,408	11,685		62,093		62,093	19	62,112			3
4	Laundry	45,253	15,009		60,262		60,262		60,262			4
5	Heat and Other Utilities			62,123	62,123		62,123	407	62,530			5
6	Maintenance	21,708	22,348	11,014	55,070		55,070	2,801	57,871			6
7	Other (specify):* Mgmt Co. Benefits							802	802			7
8	**TOTAL General Services**	210,588	144,851	73,137	428,576		428,576	5,418	433,994			8
	B. Health Care and Programs											
9	Medical Director			8,450	8,450		8,450		8,450			9
10	Nursing and Medical Records	539,461	46,748	900	587,109		587,109	9,850	596,959			10
10a	Therapy		1,392	101,970	103,362		103,362	4	103,366			10a
11	Activities	18,867	15	1,060	19,942		19,942	4	19,946			11
12	Social Services	24,912			24,912		24,912		24,912			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt Co. Benefits							952	952			15
16	**TOTAL Health Care and Programs**	583,240	48,155	112,380	743,775		743,775	10,810	754,585			16
	C. General Administration											
17	Administrative	31,771		184,821	216,592		216,592	(129,808)	86,784			17
18	Directors Fees											18
19	Professional Services			25,111	25,111		25,111	9,937	35,048			19
20	Dues, Fees, Subscriptions & Promotions			1,771	1,771		1,771	408	2,179			20
21	Clerical & General Office Expenses		4,252	32,215	36,467		36,467	33,992	70,459			21
22	Employee Benefits & Payroll Taxes			140,439	140,439		140,439		140,439			22
23	Inservice Training & Education							567	567			23
24	Travel and Seminar			269	269		269	1,203	1,472			24
25	Other Admin. Staff Transportation			32,427	32,427		32,427	2,313	34,740			25
26	Insurance-Prop.Liab.Malpractice			51,946	51,946		51,946	809	52,755			26
27	Other (specify):* Mgmt Co. Benefits							9,331	9,331			27
28	**TOTAL General Administration**	31,771	4,252	468,999	505,022		505,022	(71,248)	433,774			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	825,599	197,258	654,516	1,677,373		1,677,373	(55,020)	1,622,353			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Bement Health Care Center #0046052 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			32,291	32,291		32,291	21,426	53,717			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			100,839	100,839		100,839	4,473	105,312			32
33	Real Estate Taxes			31,465	31,465		31,465	297	31,762			33
34	Rent-Facility & Grounds							2,320	2,320			34
35	Rent-Equipment & Vehicles			125	125		125	81	206			35
36	Other (specify):*											36
37	**TOTAL Ownership**			164,720	164,720		164,720	28,597	193,317			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		25,427		25,427		25,427		25,427			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,940	32,940		32,940		32,940			42
43	Other (specify):* Nonallowable Costs			20,417	20,417		20,417	(20,417)				43
44	**TOTAL Special Cost Centers**		25,427	53,357	78,784		78,784	(20,417)	58,367			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	825,599	222,685	872,593	1,920,877		1,920,877	(46,840)	1,874,037			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(686)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	17,418	30		9
10	Interest and Other Investment Income	(107)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(792)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,360)	43		18
19	Entertainment				19
20	Contributions	3	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,475)	43		24
25	Fund Raising, Advertising and Promotional	(1,541)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG 5A	(10,697)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (6,237)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(40,603)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (40,603)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (46,840)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Bement Health Care Center

ID# 0046052

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medicare labs	$ (4,121)	43	1
2	Medicare xrays	(3,445)	43	2
3	Chamber of Commerce dues	(35)	20	3
4	Offset meal income	(3,096)	2	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(10,697)		49

Bement Health Care Center
Provider #: 0046052
01/01/04 to 12/31/04 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	4,483	0	0	0	0	0	0	0	0	0	4,483	1
2	Food Purchase	(3,096)	2	0	0	0	0	0	0	0	0	0	(3,094)	2
3	Housekeeping	0	19	0	0	0	0	0	0	0	0	0	19	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	407	0	0	0	0	0	0	0	0	0	407	5
6	Maintenance	0	2,801	0	0	0	0	0	0	0	0	0	2,801	6
7	Other (specify):*	0	802	0	0	0	0	0	0	0	0	0	802	7
8	**TOTAL General Services**	(3,096)	8,514	0	0	0	0	0	0	0	0	0	5,418	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	9,850	0	0	0	0	0	0	0	0	0	9,850	10
10a	Therapy	0	4	0	0	0	0	0	0	0	0	0	4	10a
11	Activities	0	4	0	0	0	0	0	0	0	0	0	4	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	952	0	0	0	0	0	0	0	0	0	952	15
16	**TOTAL Health Care and Programs**	0	10,810	0	0	0	0	0	0	0	0	0	10,810	16
	C. General Administration													
17	Administrative	0	(129,808)	0	0	0	0	0	0	0	0	0	(129,808)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,937	0	0	0	0	0	0	0	0	0	9,937	19
20	Fees, Subscriptions & Promotions	(35)	443	0	0	0	0	0	0	0	0	0	408	20
21	Clerical & General Office Expenses	0	0	33,992	0	0	0	0	0	0	0	0	33,992	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	567	0	0	0	0	0	0	0	0	567	23
24	Travel and Seminar	0	0	1,203	0	0	0	0	0	0	0	0	1,203	24
25	Other Admin. Staff Transportation	0	0	2,313	0	0	0	0	0	0	0	0	2,313	25
26	Insurance-Prop.Liab.Malpractice	0	0	809	0	0	0	0	0	0	0	0	809	26
27	Other (specify):*	0	0	9,331	0	0	0	0	0	0	0	0	9,331	27
28	**TOTAL General Administration**	(35)	(119,428)	48,215	0	0	0	0	0	0	0	0	(71,248)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,131)	(100,104)	48,215	0	0	0	0	0	0	0	0	(55,020)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bement Health Care Center # 0046052 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	17,418	0	4,008	0	0	0	0	0	0	0	0	21,426	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(107)	0	4,580	0	0	0	0	0	0	0	0	4,473	32
33	Real Estate Taxes	0	0	297	0	0	0	0	0	0	0	0	297	33
34	Rent-Facility & Grounds	0	0	2,320	0	0	0	0	0	0	0	0	2,320	34
35	Rent-Equipment & Vehicles	0	0	81	0	0	0	0	0	0	0	0	81	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	17,311	0	11,286	0	0	0	0	0	0	0	0	28,597	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(20,417)	0	0	0	0	0	0	0	0	0	0	(20,417)	43
44	**TOTAL Special Cost Centers**	(20,417)	0	0	0	0	0	0	0	0	0	0	(20,417)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(6,237)	(100,104)	59,501	0	0	0	0	0	0	0	0	(46,840)	45

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See attached Schedule 6A		See attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 4,483	$ 4,483	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	2	2	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	19	19	3
4	V	5	Utilities		Petersen Health Care, Inc.	100.00%	407	407	4
5	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	2,801	2,801	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	802	802	6
7	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	9,850	9,850	7
8	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	4	4	8
9	V	11	Activities		Petersen Health Care, Inc.	100.00%	4	4	9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	952	952	10
11	V	17	Administrative	184,821	Petersen Health Care, Inc.	100.00%	55,013	(129,808)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	9,937	9,937	12
13	V	20	Dues, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	443	443	13
14	Total			$ 184,821			$ 84,717	$ * (100,104)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	Clerical & General Office	$	Petersen Health Care, Inc.	100.00%	$ 33,992	$ 33,992	15
16	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	567	567	16
17	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	1,203	1,203	17
18	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,313	2,313	18
19	V	26	Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	809	809	19
20	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	9,331	9,331	20
21	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	4,008	4,008	21
22	V	32	Interest		Petersen Health Care, Inc.	100.00%	4,580	4,580	22
23	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	297	297	23
24	V	34	Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	2,320	2,320	24
25	V	35	Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	81	81	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 59,501	$ * 59,501	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Bement Health Care Center
0046052
12/31/2004

Schedule 6A

VII Related Parties - Page 6

Related Nursing Homes	City
In-State:	
Arcola Health Care Center	Arcola, IL
Bement Health Care Center	Bement, IL
Casey Health Care Center	Casey, IL
Countryview Terrace	Louisville, IL
Eastview Terrace	Sullivan, IL
El Paso Health Care Center	El Paso, IL
Flora Health Care Center	Flora, IL
Havana Health Care Center	Havana, IL
Kewanee Care Home	Kewanee, IL
Palm Terrace of Mattoon	Mattoon, IL
Prairie Rose Health Care Center	Pana, IL
Robings Manor Nursing Home	Brighton, IL
Royal Oaks Care Center	Kewanee, IL
Sheldon Health Care Center	Sheldon, IL
Sullivan Health Care Center	Sullivan, IL
Sunset Manor Nursing Home	Canton, IL
Tuscola Health Care Center	Tuscola, IL
Out-of-State:	
Meadow Lawn Nursing Center	Davenport, IA

Related Assisted Living	
Kewanee Courtyard Estates	Kewanee, IL
Kewanee Courtyard Village	Kewanee, IL
Monmouth Courtyard Estates	Monmouth, IL

Other Related Business Entities		
Petersen Health Care, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Health Care II, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Enterprises	Peoria, IL	Management/Bookkeeping
Petersen Health Systems	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Mark Petersen	President	Administrative	100.00	1,037,976	2.5	5.00	Salary	$ 55,013	L17, C8	1
2											2
3											3
4											4
5											5
6			See attached Schedule 7A								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 55,013		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Bement Health Care Center
0046052
12/31/2004

Schedule 7A

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

Name	Arcola Health Care Center	Bement Health Care Center	Casey Health Care Center	Countryview Terrace	Eastview Terrace	El Paso Health Care Center	Flora Health Care Center	Havana Health Care Center	Kewanee Care Center	Meadow Lawn Nursing Center	Palm Terrace of Mattoon	Prairie Rose Health Care Center	Robings Manor Nursing Home	Royal Oaks Care Center	Sheldon Health Care Center	Sullivan Health Care Center	Sunset Manor Nursing Home	Tuscola Health Care Center	TOTAL
Mark Petersen	90,072	55,013	25,865	15,145	58,361	74,717	10,659	72,956	69,335	54,095	111,582	77,674	64,047	91,387	33,271	68,050	101,105	19,655	1,092,989

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Peteresen Health Care, Inc.
Street Address: 7218 North Villa Lake
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	409,056	18	$ 89,079	$ 89,071	20,589	$ 4,483	1
2	2	Food	Patient Days	409,056	18	33		20,589	2	2
3	3	Housekeeping	Patient Days	409,056	18	372		20,589	19	3
4	5	Utilities	Patient Days	409,056	18	8,082		20,589	407	4
5	6	Maintenance	Patient Days	409,056	18	55,644	49,773	20,589	2,801	5
6	7	Mgmt. Allocation of Benefits	Patient Days	409,056	18	15,931		20,589	802	6
7	10	Nursing and Medical Records	Patient Days	409,056	18	195,694	164,789	20,589	9,850	7
8	10A	Therapy	Patient Days	409,056	18	75		20,589	4	8
9	11	Activities	Patient Days	409,056	18	86		20,589	4	9
10	15	Mgmt. Allocation of Benefits	Patient Days	409,056	18	18,908		20,589	952	10
11	17	Administrative	Patient Days	409,056	18	1,092,989	1,092,989	20,589	55,013	11
12	19	Professional Services	Patient Days	409,056	18	197,418		20,589	9,937	12
13	20	Dues, Fees, Subs & Promos	Patient Days	409,056	18	8,792		20,589	443	13
14	21	Clerical & General Office	Patient Days	409,056	18	675,343	522,789	20,589	33,992	14
15	23	Inservice Training & Education	Patient Days	409,056	18	11,260		20,589	567	15
16	24	Travel and Seminar	Patient Days	409,056	18	23,910		20,589	1,203	16
17	25	Other Admin. Staff Transport.	Patient Days	409,056	18	45,949		20,589	2,313	17
18	26	Insurance-Prop.Liab.Mal.	Patient Days	409,056	18	16,073		20,589	809	18
19	27	Mgmt. Allocation of Benefits	Patient Days	409,056	18	185,395		20,589	9,331	19
20	30	Depreciation	Patient Days	409,056	18	79,620		20,589	4,008	20
21	32	Interest	Patient Days	409,056	18	90,987		20,589	4,580	21
22	33	Real Estate Taxes	Patient Days	409,056	18	5,910		20,589	297	22
23	34	Rent - Facility & Grounds	Patient Days	409,056	18	46,102		20,589	2,320	23
24	35	Rent - Equipment & Vehicles	Patient Days	409,056	18	1,612		20,589	81	24
25	TOTALS					$ 2,865,264	$ 1,919,411		$ 144,218	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	LaSalle Bank		X	Mortgage	$1,946.56	08/31/02	$ 1,797,235	$ 1,740,604	08/01/07	varies	$ 94,219	1
2	Bank of Farmington		X	Van Purchase	$997.95	07/31/01	35,926		08/30/04	0.0875	4,833	2
3												3
4												4
5												5
	Working Capital											
6	Adkins Commercial Brokerage		X	Commercial Note	$167.00	09/10/96	22,500		08/10/06	0.0900	1,787	6
7												7
8												8
9	TOTAL Facility Related				$3,111.51		$ 1,855,661	$ 1,740,604			$ 100,839	9
	B. Non-Facility Related*											
10								Home Office Allocation			4,580	10
11												11
12												12
13								Less: Interest income offset			(107)	13
14	TOTAL Non-Facility Related						$	$			$ 4,473	14
15	TOTALS (line 9+line14)						$ 1,855,661	$ 1,740,604			$ 105,312	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.		$ 32,700	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	$ 32,082	2
3. Under or (over) accrual (line 2 minus line 1).		$ (618)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 32,083	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.	Home Office Allocation	297	
TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 31,762	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	28,964	8
	2000	29,172	9
	2001	30,442	10
	2002	32,667	11
	2003	32,082	12

Accrual is equal to 100% of the 2003 real estate tax bill.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bement Health Care Center COUNTY Piatt

FACILITY IDPH LICENSE NUMBER 0046052

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 678-2191 FAX #: (309) 678-7521

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	01-00-07-000-609-00	Bement Health Care Center	$ 32,082.00	$ 32,082.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 32,082.00	$ 32,082.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,000 B. General Construction Type: Exterior Block Frame Wood Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	109,829	1996	$ 33,600	1
2					2
3	TOTALS	109,829		$ 33,600	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1996		$ 780,146	$ 20,004	35	$ 22,290	$ 2,286	$ 198,753	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping			1996	3,650	217	20	183	(34)	1,571	9
10	Parking Lot			1996	1,669	99	20	83	(16)	687	10
11	Driveway			1996	1,050	62	20	53	(9)	449	11
12	Painting and Remodeling			1996	3,155	141	20	158	17	1,342	12
13	Curtains			1996	4,928	220	20	243	23	2,112	13
14	Walkway			1996	361	90	20	18	(72)	156	14
15	Alarm and Fire Equipment			1996	4,437	198	20	222	24	1,906	15
16	Sign			1996	434	19	20	22	3	211	16
17	Heating and Unit Platform			1996	1,219	54	20	61	7	600	17
18	300 Gallon Tank			1997	1,370	35	20	69	34	551	18
19	Install Gas Line			1997	1,861	48	20	93	45	729	19
20	Steel Door			1997	1,170	30	20	59	29	461	20
21	New Gas Line			1997	1,875	48	20	94	46	681	21
22	Gas Water Heater			1997	5,008	128	20	250	122	1,793	22
23	Zone Line Heaters			1997	730	65	20	37	(28)	280	23
24	Zone Line Heaters			1997	754	67	20	38	(29)	278	24
25	Generator Repair			1997	6,112		20	306	306	2,167	25
26	Ase Blacktop			1998	10,062	619	20	503	(116)	3,270	26
27	Electrical Service Generator Work			1998	1,846	47	20	92	45	599	27
28	Zone Line Heaters			1998	716	63	20	36	(27)	233	28
29	Heater			1999	4,956	442	20	248	(194)	1,363	29
30	Kickplates, Handrails			1999	1,803	46	20	90	44	495	30
31	Grade Driveway and Parking Lot			1999	3,100	215	20	155	(60)	853	31
32	Parking Lot Sealant			1999	1,060	73	20	53	(20)	292	32
33	Garage			2000	8,892	228	20	445	217	2,001	33
34	Door Frame Protectors			2000	1,059	27	20	53	26	238	34
35	Nine Windows			2000	2,290	59	20	114	55	514	35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Zone Line Heater	2000	$ 1,312	$ 164	20	$ 66	$ (98)	$ 296	37
38	Carpet	2001	1,297	227	7	185	(42)	649	38
39	Fire system	2001	22,829	585	39	585		2,049	39
40	Air System	2001	9,985	256	39	256		896	40
41	Fire Door	2001	825	21	39	21		75	41
42	Water Heater	2002	3,976	681	39	102	(579)	306	42
43	Gutters	2004	6,783	87	39	87		87	43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 902,720	$ 25,365		$ 27,370	$ 2,005	$ 228,943	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 145,660	$ 10,211	$ 15,855	$ 5,644	10	$ 117,874	71
72	Current Year Purchases	2,661	397	184	(213)	7-10	184	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			4,008	4,008			74
75	TOTALS	$ 148,321	$ 10,608	$ 20,047	$ 9,439		$ 118,058	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility use	1995 Dodge Truck	2001	$ 31,500	$ 6,049	$ 6,300	$ 251	5	$ 22,050	76
77										77
78										78
79										79
80	TOTALS			$ 31,500	$ 6,049	$ 6,300	$ 251		$ 22,050	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,116,141	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 42,022	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 53,717	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 11,695	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 369,051	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6		Allocated from Home Office			2,320			6
7	TOTAL				$ 2,320 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A . N/A

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 206 Description: Laundry equipment - 125; Home Office Allocation - 81
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	995	$	49,738	$	995	$ 49,738	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		125		6,271		125	6,271	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10A(3)	hrs		871		43,571	1,392	871	44,963	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39(2)	# of prescrpts					20,471		20,471	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): See Schedule 16A	See Sch. 16A			80		2,390	4,956	80	7,346	13
14	TOTAL			$	2,071	$	101,970	$ 26,819	2,071	$ 128,789	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Bement Health Care Center
Provider #: 0046052
01/01/04 to 12/31/04 **Schedule 16A**

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
Oxygen	39(2)			4,956
Rehab Therapy	10A(3)	80	2,390	
		80	2,390	4,956

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 883,722	$ 883,722	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance -0-)	189,116	189,116	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,163	5,163	7
8	Accounts Receivable (owners or related parties)	554,208	554,208	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,632,209	$ 1,632,209	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	44,129	33,600	13
14	Buildings, at Historical Cost	887,076	902,720	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	193,918	179,821	16
17	Accumulated Depreciation (book methods)	(387,175)	(369,051)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 737,948	$ 747,090	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,370,157	$ 2,379,299	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 224,641	$ 224,641	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	67,727	67,727	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,083	32,083	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses - Other	6,758	6,758	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 331,209	$ 331,209	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,740,604	1,740,604	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,740,604	$ 1,740,604	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,071,813	$ 2,071,813	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 298,344	$ 307,486	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,370,157	$ 2,379,299	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Bement Health Care Center
Provider #: 0046052
01/01/04 to 12/31/04 **Schedule 17A**

XV. Balance Sheet

Line 36 - Other Current Liabilities:

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 94,904	1
2	Restatements (describe):		2
3			3
4	**Prior period adjustment**	(39,690)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 55,214	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	243,130	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 243,130	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 298,344	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,910,049	1
2	Discounts and Allowances for all Levels	26,795	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,936,844	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	176,180	6
7	Oxygen	6,036	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 182,216	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,096	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	28,504	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,647	19
20	Radiology and X-Ray		20
21	Other Medical Services	8,205	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 43,452	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	107	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 107	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Transportation revenue**	578	28
28a	**Vending income**	810	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,388	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,164,007	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	428,576	31
32	Health Care	743,775	32
33	General Administration	505,022	33
	B. Capital Expense		
34	Ownership	164,720	34
	C. Ancillary Expense		
35	Special Cost Centers	45,844	35
36	Provider Participation Fee	32,940	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,920,877	40
41	**Income before Income Taxes (line 30 minus line 40)****	243,130	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 243,130	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity is a cash basis taxpayer.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,387	1,387	$ 26,600	$ 19.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,296	5,520	104,170	18.87	3
4	Licensed Practical Nurses	4,829	4,914	74,055	15.07	4
5	Nurse Aides & Orderlies	31,619	32,947	301,534	9.15	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,560	1,560	17,551	11.25	9
10	Activity Assistants	206	213	1,316	6.18	10
11	Social Service Workers	2,080	2,080	24,912	11.98	11
12	Dietician					12
13	Food Service Supervisor	2,547	2,547	21,497	8.44	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,020	10,214	71,722	7.02	15
16	Dishwashers					16
17	Maintenance Workers	2,015	2,015	21,708	10.77	17
18	Housekeepers	7,084	7,218	50,408	6.98	18
19	Laundry	5,764	6,028	45,253	7.51	19
20	Administrator	2,080	2,080	31,771	15.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca Care Plan Coord	1,993	1,993	33,102	16.61	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	78,480	80,716	$ 825,599 *	$ 10.23	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	8,450	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	900	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 9,350		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	N/A			51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Angela Edwards	Admnistrator	0	$ 31,771
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 31,771

B. Administrative - Other

Description	Amount
Management fees - eliminated in column 7	$ 184,821
TOTAL (agree to Schedule V, line 17, col. 3)	$ 184,821
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Ginoli & Company	Accounting	$ 6,000
Altschuler, Melvoin & Glasser	Accounting	9,330
Bush, Snyder & Associates	Legal	2,433
IVANS	Computer Services	603
ADP	Computer Services	4,919
LTC Solutions	Computer Services	1,320
Arch Wireless	Computer Services	88
Americ On Line	Computer Services	299
AdminaStar Federal	Computer Services	119
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 25,111

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 22,561
Unemployment Compensation Insurance	12,257
FICA Taxes	60,085
Employee Health Insurance	38,407
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	340
401(k)	1,596
Employee Morale	5,193
TOTAL (agree to Schedule V, line 22, col.8)	$ 140,439

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,232
Health Care Worker Background Check	
(Indicate # of checks performed 20)	245
Miscellaneous Dues	194
Licenses & Permits	100
Home Office Allocation	443
Less: Public Relations Expense	(35)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,179

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	119
Seminar Expense	150
Home Office Allocation	1,203
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,472

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Bement Health Care Center
Provider #: 0046052
01/01/04 to 12/31/04 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	25,111
Allocated from Management Company - Legal	1,625
Allocated from Management Company - Other	8,312
Total (agree to Schedule V, line 19, column 8)	35,048

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3								N/A					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0046052 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,802** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **32,940**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,096**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli & Company** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit is currently in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	93,219	7,543	0	100,762	0	100,762	4,483	105,245
2. Food Purchase	0	88,266	0	88,266	0	88,266	-3,094	85,172
3. Housekeeping	50,408	11,685	0	62,093	0	62,093	19	62,112
4. Laundry	45,253	15,009	0	60,262	0	60,262	0	60,262
5. Heat and Other Utilities	0	0	62,123	62,123	0	62,123	407	62,530
6. Maintenance	21,708	22,348	11,014	55,070	0	55,070	2,801	57,871
7. Other (specify)*	0	0	0	0	0	0	802	802
8. Total General Services	210,588	144,851	73,137	428,576	0	428,576	5,418	433,994
9. Medical Director	0	0	8,450	8,450	0	8,450	0	8,450
10. Nursing & Medical Records	539,461	46,748	900	587,109	0	587,109	9,850	596,959
10a. Therapy	0	1,392	101,970	103,362	0	103,362	4	103,366
11. Activities	18,867	15	1,060	19,942	0	19,942	4	19,946
12. Social Services	24,912	0	0	24,912	0	24,912	0	24,912
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	952	952
16. Total Health Care & Programs	583,240	48,155	112,380	743,775	0	743,775	10,810	754,585
17. Administrative	31,771	0	184,821	216,592	0	216,592	-129,808	86,784
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	25,111	25,111	0	25,111	9,937	35,048
20. Fees, Subscriptions & Promotion	0	0	1,771	1,771	0	1,771	408	2,179
21. Clerical & General Office	0	4,252	32,215	36,467	0	36,467	33,992	70,459
22. Employee Benefits & Payroll	0	0	140,439	140,439	0	140,439	0	140,439
23. Inservice Training & Education	0	0	0	0	0	0	567	567
24. Travel and Seminar	0	0	269	269	0	269	1,203	1,472
25. Other Admin. Staff Trans	0	0	32,427	32,427	0	32,427	2,313	34,740
26. Insurance-Prop.Liab.Malpractice	0	0	51,946	51,946	0	51,946	809	52,755
27. Other (specify)*	0	0	0	0	0	0	9,331	9,331
28. Total General Adminis	31,771	4,252	468,999	505,022	0	505,022	-71,248	433,774
29. Total General Administrative	825,599	197,258	654,516	1,677,373	0	1,677,373	-55,020	1,622,353
30. Depreciation	0	0	32,291	32,291	0	32,291	21,426	53,717
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	100,839	100,839	0	100,839	4,473	105,312
33. Real Estate	0	0	31,465	31,465	0	31,465	297	31,762
34. Rent - Facility & Grounds	0	0	0	0	0	0	2,320	2,320
35. Rent - Equipment & Vehicles	0	0	125	125	0	125	81	206
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	164,720	164,720	0	164,720	28,597	193,317
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	25,427	0	25,427	0	25,427	0	25,427
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	32,940	32,940	0	32,940	0	32,940
43. Other (specify):*	0	0	20,417	20,417	0	20,417	-20,417	0
44. Total Special Cost Ce	0	25,427	53,357	78,784	0	78,784	-20,417	58,367
45. Grand Total	825,599	222,685	872,593	1,920,877	0	1,920,877	-46,840	1,874,037

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	883,722	883,722
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	189,116	189,116
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	5,163	5,163
8. Accounts Receivable-Owner/Related Party	554,208	554,208
9. Other (specify):	0	0
10. Total current assets	1,632,209	1,632,209
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	44,129	33,600
14. Buildings, at Historical Cost	887,076	902,720
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	193,918	179,821
17. Accumulated Depreciation (book methods)	-387,175	-369,051
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	737,948	747,090
25. Total Assets	2,370,157	2,379,299
CURRENT LIABILITIES		
26. Accounts Payable	224,641	224,641
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	67,727	67,727
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	32,083	32,083
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	6,758	6,758
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	331,209	331,209
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	1,740,604	1,740,604
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	1,740,604	1,740,604
46.Total Liabilities	2,071,813	2,071,813
47.Total Equity	298,344	307,486
48.Total Liabilities and Equity	2,370,157	2,379,299

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,910,049
2. Discounts and Allowances for all Levels	26,795
Subtotal - Inpatient Care	1,936,844
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	176,180
7. Oxygen	6,036
Subtotal - Anciliary Revenue	182,216
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	3,096
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	28,504
18. Sale of Supplies to Non-Patients	0
19. Laboratory	3,647
20. Radiologyand X-Ray	0
21. Other Medical Services	8,205
22. Laundry	0
Subtotal - Other Operating Revenue	43,452
24. Contributions	0
25. Interest and Other Investments Income	107
Subtotal - Non-Operating Revenue	107
27. Other Revenue (specify):	1,388
28. Other Revenue (specify):	0
Subtotal - Other Revenue	1,388
30. Total Revenue	2,164,007
31. General Services	428,576
32. Health Care	743,775
33. General Administration	505,022
34. Ownership	164,720
35. Special Cost Centers	45,844
35. Provider Participation Fee	32,940
37. Other	0
40. Total Expenses	1,920,877
41. Income Before Income Taxes	243,130
42. Income Taxes	0
43. Net Income or Loss for the Year	243,130

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